LEC MEDI-CAL ADMINISTRATIVE ACTIVITIES (MAA)
SUMMARY INVOICE

(7/2006)

Claiming Unit Name	0	Date	1/0/1900
DHS Contractor (Region)	0	Contract year/quarter	0
Contract #	0	Period of Service	0

Type of Invoice (check one):

Original Invoice ☐

Revised Invoice ☐

Corrected Invoice ☐

Enter the Total Amount Previously Reimbursed for the Period of Service	$
Amount Previously Over or Under Reimbursed for the Period of Service	$ 0
TOTAL to be Reimbursed by Federal Government Representing 50% Share	$ #DIV/0!

I certify under penalty of perjury that the information provided on this invoice is true and correct, based on actual expenditures of the claiming unit incurred for the period claimed, and that the funds/contributions expended, as necessary for federal matching funds pursuant to the requirement of 42 CFR 433.51, allowable administrative activities and that these claimed expenditures have not previously been nor shall not subsequently be used for federal match in this or any other program. I have notice that this information is to be used for filing of a claim with the Federal government for Federal funds and that knowing misrepresentation constitutes violation of the Federal False Claims Act.

Typed Name of Signer

LEC Coordinator Signature

Title

Date

For DHS Program Use Only

I hereby certify to the best of my knowledge and belief that the claims submitted and attached herein, are claims for the Medicaid program under Title XIX of the Social Security Act (the Act), and as applicable, under the State Children's Health Insurance Program (SCHIP) under Title XXI of the Act, and are allowable in accordance with applicable implementing federal, state, and local statutes, regulations, policies, and the state plan (including any approved waivers of the state plan) approved by the Secretary and in effect at the corresponding time commensurate with the claims aforementioned and furthermore, I certify that federal matching funds are not being claimed for any expenditure under Medicaid and/or SCHIP state plan amendment that was submitted after January 2, 2001, and that has not been approved by the Secretary effective for the applicable quarter associated with the claims aforementioned. Further, I direct the Accounting Section to process the attached claims for payment certifying to the best of my knowledge and belief that the payee has met the contractual conditions for such payment(s) and the following accounting codes are appropriate for such payment(s). This invoice has been checked against our records and found to be the original one presented for payment and has not previously been paid. We have recorded this payment so as to prevent a later duplicate payment.

Signed

SSMI
Title

Date

Analyst Initials

CALSTARS Code 0__-95929-9912-702-42-60 LEC

Department of Health Services
Medi-Cal Benefits Branch
Medi-Cal Administrative Activities
1501 Capital Avenue, MS 4600
PO Box 997413
Sacramento, CA 95899-7413